~~ARIZONA DEPARTMENT OF HEALTH~~ ~~DEPARTMENT~~
ARIZONA HEALTHCARE COST ~~SERVICES~~ CONTAINMENT SYSTEM

~~Policy 406, Attachment 7~~

COMMUNITY SERVICE AGENCY NOTICE OF DEFICIENCY

~~COMMUNITY SERVICE AGENCY TITLE XIX CERTIFICATION~~

~~NOTICE OF DEFICIENCY~~

Date:

Applicant/Agency Name:

Address

Requestor Name

Agency

Telephone Number

Item(s) Requiring Corrective Action	Timeframe/Comments	Applicant Corrective Action Plan
☐ Reason for amendment		
☐ Provider ID/NPI		
☐ Provider Name		
☐ Provider Address(es)		
☐ Program Director's Information		
☐ ~~T~~/RBHA affiliation		
☐ Tax ID#/Social Security Number		
☐ Provider Incorporation Documents		
☐ Provider Charter		
☐ Occupancy Permit		
☐ Fire inspection		
☐ Services Provided		
☐ Age Groups		
☐ Direct Service Staff/Contractor List		
☐ Proof of age		
☐ Reference form		
☐ Driver's license		
☐ Vehicle registration		
☐ Current liability insurance		
☐ Credible evidence of BHP		

☐

~~ARIZONA DEPARTMENT OF HEALTH~~ ~~SERVICES~~
ARIZONA HEALTHCARE COST CONTAINMENT SYSTEM
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☐ Credible evidence of BHT		
☐ Credible evidence of BHPP		
☐ Credible evidence of one (1) year work experience in providing _____ rehabilitation services to persons with disabilities		
☐ Fingerprint Clearance Card		
☐ Fingerprint Clearance Card Application		
☐ State of Arizona Criminal History Affidavit		
☐ AHCCCS~~DHS/DBHS~~ Self-Declaration of Criminal History		
☐ CPR Certificate		
☐ First Aid Training		
☐ TB Documentation		
☐ Training checklist		
☐ Training documentation		

Please forward the Corrective Action Plan and corresponding documentation to the requestor indicated above by the specified timeframe(s).

Please provide the aforementioned documents and/or clarification by [Date – 10 business days][1].

[1] Added due date to comport with policy.